KCDRB Form #1

APPLICATION FOR LEOFF-I DISABILITY-RETIREMENT BENEFITS

(to be completed by LEOFF-I Employee/applicant)

"I submit this application for LEOFF-I disability/retirement leave benefits according to the provisions of RCW 41.26, WAC 415.150, and King County LEOFF-I Disability Retirement Board Rules and policies."

I. _____ _____

Name **Social Security No.**

_____ _____ / _____

Address Date of Birth / Date of Hire

_____ _____

City, State, Zip Code Telephone No.

II. Specific position/ rank / unit currently assigned:

_____

Employer/Dist.: _____ _____

Telephone No.

Address: _____

III. The first day of disability leave commenced on this date: _____

[month, date, year]

Upon regular review by the board during this leave period, if the written medical evidence I submit from my physician(s) supports continuous disability, such that I am unable to perform the regular duties of my position with average efficiency, and indicate that disability leave must extend throughout a continuous six-month period, my last day of active-service status will be (six-months from the first day disability leave commenced): _____.

[month, date, year]

IV. I returned to duty on this date: _____.

[month, date, year]

V. Use of sick or vacation leave benefits.

[__] My employer/dept. <u>does not</u> provide sick leave benefits.

[__] My employer/dept. <u>does</u> provide sick leave benefits.

[__] I <u>did not</u> use any sick leave or vacation leave benefits before applying for LEOFF-I benefits.

[__] I <u>did use</u> [sick] or [vacation] leave benefits before applying for LEOFF-I benefits on these dates:

VI. Describe fully the date, place, cause and nature of the disability.
Attach any supportive information such as accident reports and medical exam reports taken at the time of the accident/injury/illness:

VII. Burden of Proof.

"I have read and understand that under WAC 415-105-040(2), "The burden of proving the extence of a disabling condition, and whether or not the condition was incurred in the line of duty, shall be upon the applicant.

Further, I understand if the medical evidence supports continuous disability and finds me eligible for disability retirement consideration, the King County LEOFF-I Board holds final jurisdiction of the line of duty finding which cannot be appealed to the WA State Retirement Systems Director."

[__] My disability was not incurred in the line of duty.

[__] I believe my disability was incurred in the line of duty and submit the following information for the board's retirement consideration: (member's explanation, dates of accident with copies of medical reports attached):

VIII. Did the disability incur while you were engaged in other employment?

[__] My disability was not incurred while engaged in other employment.

[__] My disability did incur while engaged in other employment. Attached is my explanation or employer's report.

IX. Medical information.

A signed affidavit (KCDRB Form #3) and/or a signed medical report letter from my physician(s) is attached with this claim. In addition, I've attached a list of all medical providers/physicians I have consulted within the last six-months related to this LEOFF-I benefits claim.

I give consent to be examined by any board-selected physician(s) required to determine my eligibility for LEOFF-I disability/retirement benefits.

Release of medical report/information. For the purposes of verifying my eligibility for benefits under the LEOFF-I statutes, I hereby authorize the release of records (copies of, not originals) contained in my LEOFF-I disability/retirement application file to requesting parties, such as my LEOFF-I employer personnel or fiscal dept., health provider, board-referred physicians/consultants, or other.

I reserve the right to be notified of all parties requesting such. I understand that all information included in my disability/retirement claim file will be forwarded to the Washington State Office of Retirement Systems and made part of a permanent record there, and is subject to inspection under the Public Records Act.

X. Member Certification.

"I HEREBY CERTIFY that all the information herein are true and correct to the best of my knowledge and belief. I have attached a signed affidavit(s) by my treating physician(s) with respect to my disability and authorize them to supply the King County LEOFF-I Disability Retirement Board with medical information requested."

Job Description. I have included a copy of my present position duties or job description provided by my LEOFF-I employer personnel department or supervisory officer/chief.

_____ _____

Signature of LEOFF-I member applicant Date

King County LEOFF-I Disability Retirement Board
Exchange Building, 821 Second Ave., MS: EXC-ES-0300
Seattle, Washington 98104-1598
(206) 263-6394